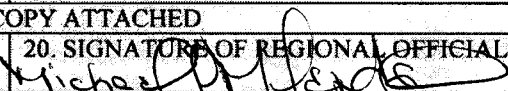


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: #11-07-A	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2011	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/11-09/30/11 \$ 4.03 million b. FFY 10/01/11-09/30/12 \$ 7.55 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1.1, 1.2, 1.3, 1.4		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>):	
10. SUBJECT OF AMENDMENT: Supplemental Medicaid payment for SUNY Physicians (FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: New York State Department of Health Bureau of HCRA Oper & Financial Analysis 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: January 15, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: February 25, 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Michael Melendez		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS:			